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# WHAT TO DO, WHAT TO DO: EMPLOYER HEALTH BENEFIT PLANS DURING AND AFTER 2012'S UNCERTAINTY

*Susan E. Cancelosi\**

## I. INTRODUCTION

Congress in March 2010 passed the Patient Protection and Affordable Care Act<sup>1</sup> and almost immediately followed with amendments in the Health Care and Education Reconciliation Act of 2010<sup>2</sup> (together, the "Act"). From any perspective, passage of the Act constituted an historic step toward reform of the United States healthcare system. Much less clear, however, has been the Act's future. Almost exactly two years after the Act made it through Congress, the U.S. Supreme Court in March 2012 devoted three days to review of key parts of the legislation.<sup>3</sup> In late June 2012, the Court upheld key components of the law.<sup>4</sup> But the Act faced yet another challenge in 2012 with the national presidential and congressional elections. The Republican Party presidential candidate, Mitt Romney, pledged early on to "work with Congress to repeal the full legislation as quickly as possible."<sup>5</sup> When Barack Obama won the presidency and the Democrats retained control of the U.S. Senate in the November 2012 elections,<sup>6</sup> the

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<sup>1</sup> Patient Protection and Affordable Care Act ("Affordable Care Act"), Pub. L. No. 111-148, 124 Stat. 119 (codified in scattered sections of 42 U.S.C.).

<sup>2</sup> Health Care and Education Reconciliation Act of 2010 ("Reconciliation Act"), Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 42 U.S.C.).

<sup>3</sup> See generally Transcript of Oral Argument, Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (No. 11-393), available at [http://www.supremecourt.gov/oral\\_arguments/argument\\_transcripts.aspx](http://www.supremecourt.gov/oral_arguments/argument_transcripts.aspx).

<sup>4</sup> Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2598 (2012); see also Adam Liptak, *Supreme Court Upholds Health Care Law, 5-4, in Victory for Obama*, N.Y. TIMES, June 29, 2012, at A1, available at [http://www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html?pagewanted=all&\\_r=0](http://www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html?pagewanted=all&_r=0).

<sup>5</sup> Shari Roan, *Romney's Pledge to Repeal Obamacare if Elected: Can He Do It?*, TAKEPART (Sept. 27, 2012), <http://www.takepart.com/article/2012/09/27/romneys-pledge-repeal-obamacare-if-elected-can-he-do-it>.

<sup>6</sup> See, e.g., Jeff Zeleny & Jim Rutenberg, *Obama's Night: Tops Romney for 2nd Term in Bruising*

specter of outright health reform repeal dissipated. Questions about implementation remain, however, and all the uncertainty has made the planning process difficult at best for employers.

Employers remain the primary source of health insurance for non-elderly Americans, with 65% of all employers offering health insurance to their employees in 2011.<sup>7</sup> Had the Act fallen, employers would have found themselves in much the same place as before 2010. With the Act now likely to reach 2014 largely intact, employers must adapt to a significant new set of obligations and potential costs.<sup>8</sup> Details remain fluid.<sup>9</sup> This Essay provides a selective overview of key provisions of the Act as currently applicable or likely to apply to employers in the near future.<sup>10</sup> The Essay also briefly discusses the Supreme Court decision that upheld key components of the Act and the effect of that decision on employer plans. Finally, the Essay offers cautious observations about employer choices as health reform takes hold.<sup>11</sup>

## II. WHAT THE ACT DOES

### A. Grandfathered Status

Neither the Employee Retirement Income Security Act of 1974 (“ERISA”),<sup>12</sup> as amended, nor the Internal Revenue Code of 1986, as amended, the two major statutes regulating employment-based health insurance before the Act, requires employers to provide any form of

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Run; *Democrats Turn Back G.O.P. Bid for Senate*, N.Y. TIMES, Nov. 7, 2012, at A1.

<sup>7</sup> KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2011 ANNUAL SURVEY 42 (2011), available at <http://ehbs.kff.org/pdf/2011/8225.pdf>. The National Compensation Survey found that 73% of the civilian workforce, including state and local government employees, had access to employment-based health insurance in March 2012. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, EMPLOYEE BENEFITS IN THE UNITED STATES—MARCH 2012, at 8 tbl.2 (2012), available at <http://www.bls.gov/news.release/pdf/ebs2.pdf>.

<sup>8</sup> Shubham Singhal et al., *Healthcare Payor & Provider Practice: How US Health Care Reform Will Affect Employee Benefits*, MCKINSEY Q., June 2011, at 1, 2–3, available at [http://www.mckinsey.com/How\\_US\\_health\\_care\\_reform\\_will\\_affect\\_employee\\_benefits\\_2813](http://www.mckinsey.com/How_US_health_care_reform_will_affect_employee_benefits_2813).

<sup>9</sup> See *infra* Part II.C.

<sup>10</sup> The Act and its underlying regulations are enormously complex. This Essay provides at best a limited summary of only a select few provisions. The materials herein incorporate relevant parts from materials I prepared for the 27th Annual Carl A. Warns, Jr. Labor & Employment Law Institute in June 2010.

<sup>11</sup> This Essay was originally drafted in the summer of 2012 before the Supreme Court upheld core provisions of the Act. The Essay was subsequently updated in the fall of 2012 before the November presidential and congressional elections. Although effort has been made to update the Essay in light of those elections, many of the thoughts contained herein reflect the intense uncertainty that existed with regard to the future of the Act throughout most of 2012.

<sup>12</sup> Employee Retirement Income Security Act of 1974 (“ERISA”), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001–1461 (2012)).

benefits to employees.<sup>13</sup> Only if an employer chooses to provide such benefits do ERISA and the Code apply.<sup>14</sup> So, too, does health reform under the Act currently affect only those employers who affirmatively choose to sponsor health plans.<sup>15</sup> Beginning in 2014, however, the Act will impose obligations on most employers without regard to whether they wish to offer health insurance, a major departure from past federal regulatory practice.<sup>16</sup>

For employers that currently sponsor health plans, whether a particular rule currently applies depends in large part on whether the plan is considered “grandfathered.”<sup>17</sup> Generally, a grandfathered plan is one in which individuals were enrolled on the date of enactment—i.e., March 23, 2010.<sup>18</sup> As long as a plan retains its grandfathered status, certain health reform provisions do not apply.<sup>19</sup> The Act, however, fails to address the specifics of how a health plan preserves its grandfathered status, providing merely that employees may re-enroll, and new employees (and their dependents) may join a plan, without negatively affecting the grandfathering.<sup>20</sup> Regulations issued a few months after the Act’s passage provide some clarification, specifying certain actions that will cause a plan (or option within a plan) to drop out of the grandfathered class.<sup>21</sup> For example, a plan’s “elimination of all or substantially all benefits to diagnose or treat a particular condition” will trigger a loss of grandfathered status, as will “[a]ny increase, measured from March 23, 2010, in a percentage cost-

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<sup>13</sup> See, e.g., COLLEEN E. MEDILL, INTRODUCTION TO EMPLOYEE BENEFITS LAW: POLICY AND PRACTICE 23 (3d ed. 2010) (“The modern employee benefits system established by ERISA makes plan sponsorship by an employer voluntary.”).

<sup>14</sup> See, e.g., *The Employee Retirement Income Security Act (ERISA)*, U.S. DEP’T OF LABOR, <http://www.dol.gov/compliance/laws/comp-erisa.htm> (last visited Apr. 29, 2013) (“ERISA does not require any employer to establish a pension plan. It only requires that those who establish plans must meet certain minimum standards.”); see also H.R. REP. NO. 93-533 (1974) (“The Internal Revenue Code provides only limited safeguards for the security of anticipated benefit rights in private plans since its primary functions are designed to produce revenue and to prevent evasion of tax obligations. The essence of enforcement under the Code lies in the power of the Internal Revenue Service to grant or disallow qualified status to a pension plan.”).

<sup>15</sup> See, e.g., *Small Business*, HEALTHCARE.GOV, <http://www.healthcare.gov/using-insurance/employers/small-business/index.html#provide> (last visited Apr. 29, 2013) (“The Affordable Care Act does not require employers to provide health insurance for their employees.”).

<sup>16</sup> See *infra* Part II.C.

<sup>17</sup> Affordable Care Act § 1251, 42 U.S.C. § 18011 (2012). If an employer maintains a health insurance plan pursuant to a collective bargaining agreement (“CBA”) that was ratified before March 23, 2010, that plan need not comply with certain of the Act’s rules until after expiration of the bargaining agreement. *Id.* § 1251(d). A collectively bargained plan protected until expiration of the controlling CBA may also qualify as a grandfathered plan—and thus still be exempt from some of the new rules even after the CBA expires. *Id.* § 1251(d)–(e).

<sup>18</sup> See *id.* § 1251.

<sup>19</sup> See *infra* Part II.B–C.

<sup>20</sup> See Affordable Care Act § 1251(a)–(c).

<sup>21</sup> Treas. Reg. § 54.9815-1251T(g)(1) (as amended in 2010).

sharing requirement (such as an individual's coinsurance requirement) . . . ."<sup>22</sup> According to the federal agencies involved, the goal is to allow grandfathered plans to "be able to make routine changes to their policies and maintain their status."<sup>23</sup>

### *B. Current Rules*

Although the most significant changes envisioned by health reform are not scheduled to take hold until 2014, the Act includes numerous small reforms intended to improve the U.S. healthcare system in the near term. The effective dates of these incremental reform steps vary, but most apply to employer plans now. The following sections highlight some of the more significant changes for employment-based plans.

#### 1. Expanded Coverage of Children

Among the more visible early changes made by the Act is a requirement that all employer-sponsored plans, including grandfathered ones, allow participants to elect medical coverage for their children until a child reaches age twenty-six, assuming the plan otherwise provides medical coverage for dependents.<sup>24</sup> Before the Act, many employer plans covered dependent adult children only if the dependents were both full-time students and under a certain age.<sup>25</sup> Young adults between eighteen and twenty-six years of age were thus often uninsured or underinsured.<sup>26</sup> Under the Act, grandfathered plans do not need to cover an adult child before January 1, 2014, if that child is eligible to enroll in another "eligible employer-sponsored health plan" (other than the group health plan of a parent).<sup>27</sup> The

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<sup>22</sup> *Id.* § 54.9815-1251T(g)(1)(i-ii).

<sup>23</sup> Press Release, U.S. Dep't of Health & Human Servs. ("HHS"), U.S. Departments of Health and Human Services, Labor, and Treasury Issue Regulation on "Grandfathered" Health Plans Under the Affordable Care Act (June 14, 2010), available at <http://www.hhs.gov/news/press/2010pres/06/20100614e.html>.

<sup>24</sup> Affordable Care Act § 1001 (adding new Public Health Service Act § 2714); *id.* § 1251 (as amended by Reconciliation Act § 2301); see also 45 C.F.R. § 147.120 (2012).

<sup>25</sup> See *Young Adult Coverage*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/features/choices/young-adult-coverage/index.html> (last updated July 6, 2012).

<sup>26</sup> See Timothy Jost, *Implementing Health Reform: Young Adult Coverage*, HEALTH AFF. BLOG (May 11, 2010, 6:43 PM), <http://healthaffairs.org/blog/2010/05/11/implementing-health-reform-young-adult-coverage/>. HHS estimated in 2010 that, of the 29.5 million individuals in this age group, 3.44 million were uninsured. See Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 27122, 27127 (May 13, 2010) (to be codified at 29 C.F.R. pt. 2590).

<sup>27</sup> Reconciliation Act § 2301; see also 45 C.F.R. § 147.120(g) (2012).

Act also prohibits the imposition of pre-existing condition exclusions with regard to covered individuals under age nineteen.<sup>28</sup>

## 2. Restricted/Prohibited Annual and Lifetime Limits

Perhaps less visible to most plan participants, but already in effect and potentially significant for employers, is a ban on lifetime dollar limits on coverage for “essential health benefits.”<sup>29</sup> For plan years beginning before January 1, 2014, the Act allows “restricted” annual limits on essential benefits coverage; beginning in 2014, annual limits are also prohibited on such coverage.<sup>30</sup> The term “essential health benefit” includes such categories as: emergency care, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, hospitalization, pediatric care, ambulatory patient services, laboratory services, certain preventive and wellness services, chronic disease management, and rehabilitative services.<sup>31</sup> Historically, plan sponsors and insurers used annual and lifetime dollar limits to cap their exposure to medical costs.<sup>32</sup> Without such limits, potentially much greater risk attaches to plan sponsorship. To assist with adjustment to the new risk, the U.S. Department of Health and Human Services (“HHS”) created a temporary waiver program that allowed certain plans to maintain lower annual limits in circumstances where compliance with the Act before 2014 “would result in a significant decrease in access to benefits under the plan . . . or would significantly increase premiums for the plan . . . .”<sup>33</sup> HHS closed the program to new waiver applications after September 22, 2011.<sup>34</sup>

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<sup>28</sup> Affordable Care Act § 1201 (adding new Public Health Service Act § 2704); *id.* § 1253 (as amended by Affordable Care Act § 10103(e)(2), (f)(1)). The prohibition on pre-existing condition exclusions is scheduled to extend to all covered individuals beginning in 2014. *Id.* § 1201 (adding new Public Health Service Act § 2704); *id.* § 1253 (as amended by Affordable Care Act § 10103(f)(1)); Reconciliation Act § 2301; *see also* 45 C.F.R. § 147.108(b) (2012).

<sup>29</sup> Affordable Care Act § 1001 (as amended by Affordable Care Act § 10101(a), adding new Public Health Service Act § 2711); *id.* § 1004; Reconciliation Act § 2301; *see also* 45 C.F.R. § 147.126 (2012).

<sup>30</sup> 45 C.F.R. § 147.126(d) (2012).

<sup>31</sup> Affordable Care Act § 1302(b).

<sup>32</sup> *See Lifetime & Annual Limits*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/features/costs/limits/index.html> (last updated Jan. 24, 2012).

<sup>33</sup> 45 C.F.R. § 147.126(d)(3) (2012).

<sup>34</sup> Press Release, Ctrs. for Medicare & Medicaid Servs., CCIIO Supplemental Guidance (CCIIO 2011-1D): Concluding the Annual Limit Waiver Application Process (June 17, 2011), *available at* [http://cciio.cms.gov/resources/files/06162011\\_annual\\_limit\\_guidance\\_2011-2012\\_final.pdf](http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf).

### 3. Expanded Reporting and Disclosure

Employer-sponsored plans have long been subject under ERISA to reporting and disclosure requirements that mandate delivery of a summary plan description (“SPD”) to participants and enumerate certain types of information that must be included.<sup>35</sup> ERISA, however, historically has allowed employers wide latitude in how they present the required information as long as an SPD is written “in a manner calculated to be understood by the average plan participant . . . .”<sup>36</sup> The Act expands on ERISA’s approach by requiring all plans—whether grandfathered or not—to provide participants with a “summary of benefits and coverage explanation” that meets standardized guidelines as to appearance, content, and language.<sup>37</sup> The new disclosure provisions generally apply as of the first day of a plan’s first open enrollment period beginning on or after September 23, 2012.<sup>38</sup>

The Act also requires employers to begin reporting the total cost of employer-sponsored medical benefits on employee W-2s.<sup>39</sup> Although the Act contemplated this requirement becoming effective for 2011, the Treasury Department and the Internal Revenue Service issued interim relief in 2010 that made reporting optional for the 2011 calendar year and subsequently issued further guidance extending relief an additional year for certain employers.<sup>40</sup> Additional reporting requirements are scheduled to become effective in 2013 and 2014.<sup>41</sup>

### 4. Restrictions on Health Spending and Similar Accounts

A number of Act provisions affect health flexible spending arrangements (“FSAs”), health savings accounts (“HSAs”), health reimbursement arrangements (“HRAs”), and other similar vehicles.<sup>42</sup> The

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<sup>35</sup> See, e.g., 29 U.S.C. § 1022 (2012).

<sup>36</sup> *Id.*

<sup>37</sup> Affordable Care Act § 1001, 42 U.S.C. § 300gg (2012) (as amended by Affordable Care Act § 10101(b)–(c), adding new Public Health Service Act § 2715); see also 45 C.F.R. § 147.200 (2012).

<sup>38</sup> 45 C.F.R. § 147.200(f) (2012).

<sup>39</sup> Affordable Care Act § 9002 (amending Internal Revenue Code § 6051(a)).

<sup>40</sup> I.R.S. Notice 2012-9, 2012-4 I.R.B. 315; I.R.S. Notice 2011-28, 2011-16 I.R.B. 656; see also Press Release, I.R.S., I.R.S. Issues Interim Guidance on Informational Reporting of Employer-Sponsored Health Coverage (Mar. 29, 2011), available at <http://www.irs.gov/newsroom/article/0,,id=237870,00.html>.

<sup>41</sup> I.R.S. Notice 2011-28, 2011-16 I.R.B. 656.

<sup>42</sup> See I.R.S. Pub. 969, Health Savings Accounts and Other Tax-Favored Health Plans (2011). A health “flexible spending arrangement,” or “FSA,” allows contributions to be made on a pre-tax basis to an individual account to be used for specified types of medical expenses. *Id.* at 15–17. Health FSAs are

specifics of such arrangements vary, but they all are intended to encourage individual awareness and responsibility for healthcare spending.<sup>43</sup> In each case, an employer, individual, or both contributes funds to a tax-advantaged individual account; the individual then controls how those funds are applied to cover acceptable health-related expenses.<sup>44</sup> The Act generally imposes new restrictions on all these types of accounts.<sup>45</sup> For example, FSAs, HSAs, and HRAs may no longer reimburse over-the-counter drugs unless they qualify as “prescribed drugs.”<sup>46</sup> Also, beginning in 2013, the Act caps contributions to an FSA through a cafeteria plan at \$2,500 (indexed for subsequent years) per participant.<sup>47</sup>

### 5. Small-Employer Tax Credit

The Act attempts to make health insurance benefits more affordable for smaller employers by offering a tax credit to offset health insurance expenses for certain small employers (generally, those with twenty-five or fewer employees, who pay no more than \$50,000 in average annual wages, and who cover at least 50% of employee healthcare premiums).<sup>48</sup> For years before 2014, the maximum tax credit for non-tax-exempt small employers is computed generally as 35% of what the small employer pays in health

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employer-sponsored plans and are often structured as an option under an employer's cafeteria plan. *Id.* at 16. Employers may contribute funds to a health FSA, but more commonly employees make the contributions by directing withholding from their pay. *Id.* at 16–17. A “health savings account,” or “HSA,” is a tax-exempt account into which funds can be deposited by an employer or individual for the individual to apply to specified types of medical expenses. *Id.* at 2. An HSA must be coupled with a so-called “high-deductible health plan,” or “HDHP,” but is not necessarily maintained by an employer. *Id.* at 3. A “health reimbursement arrangement,” or “HRA,” allows an employer to make contributions to an individual account for an employee, again to be used at the employee's direction for specified types of medical expenses. *Id.* at 17. The employer contributions are not taxable to the employee. *Id.* HRAs are employer-sponsored benefit plans, and only the employer may contribute funds to such accounts. *See id.* (providing for a taxpayer-oriented overview of the different types of tax-advantaged individual accounts available to help fund medical expenses).

<sup>43</sup> *See generally id.*

<sup>44</sup> *See id.*

<sup>45</sup> Affordable Care Act § 9003, 26 U.S.C. § 223 (2012).

<sup>46</sup> *Id.* The limitation also applies to reimbursements from an Archer medical savings account. *Id.*; *see also* I.R.S. Notice 2010-59, 2010-39 I.R.B. 396; Rev. Rul. 2010-23, 2010-39 I.R.B. 388. The rule allowing reimbursement of over-the-counter drugs through the tax-advantaged savings accounts dated back to 2003. Rev. Rul. 2003-102, 2003-38 I.R.B. 559; *see also* Press Release, I.R.S., Over-the-Counter Drugs to be Covered by Health Care Flexible Spending Accounts (Sept. 3, 2003), available at <http://www.irs.gov/uac/Over-the-Counter-Drugs-To-Be-Covered-%3Cbr%3Eby-Health-Care-Flexible-Spending-Accounts>.

<sup>47</sup> Affordable Care Act § 9005 (as amended by Affordable Care Act § 10902 and Reconciliation Act § 1403); *see also* I.R.S. Notice 2012-40, 2012-26 I.R.B. 1046.

<sup>48</sup> Affordable Care Act § 1421 (as amended by Affordable Care Act § 10105, adding Internal Revenue Code § 45R); *see also* I.R.S. Notice 2010-44, 2010-22 I.R.B. 717; I.R.S. Notice 2010-82, 2010-51 I.R.B. 857.



insurance premiums for its employees (using, however, the average premium in a specified small-group market in lieu of the actual premiums paid if the average premium amount would result in a lower tax credit amount).<sup>49</sup> The credit phases out for employers with more than ten “full-time equivalent” employees, as well as for those with average annual wages in excess of a specified level.<sup>50</sup> Beginning in 2014, the maximum percentage increases to 50%,<sup>51</sup> but is limited to a two-consecutive-year period that begins with the first year the employer offers its employees a health plan through a government-established Health Insurance Exchange.<sup>52</sup>

## 6. Retiree Health Benefit Plans

Two provisions of the Act directly affect employment-based retiree health insurance. Since 2006, employers who provide retiree prescription drug coverage have been eligible for a subsidy under Medicare as long as the retiree coverage meets certain standards.<sup>53</sup> The subsidy, which reimburses employers for 28% of a retiree’s qualified drug costs up to a specified limit, is not treated as taxable income to employers yet counts in determining the total prescription drug costs they are allowed to deduct.<sup>54</sup> Beginning in 2013, however, employers must take the subsidy into account in computing their deduction for retiree drug plan expenses, in effect lowering the available deduction.<sup>55</sup>

While lessening the value of the retiree drug plan subsidy for Medicare-eligible retirees, the Act separately created the Early Retiree Reinsurance Program (“ERRP”) to assist plans for early retirees (those at least age fifty-five but not yet Medicare-eligible).<sup>56</sup> The ERRP reimbursed qualifying employer retiree health plans for 80% of their costs per early retiree or dependent to the extent those expenses exceed \$15,000, but subject to a \$90,000 cap (a maximum of \$60,000 in reimbursement per individual per

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<sup>49</sup> Affordable Care Act § 1421 (as amended by Affordable Care Act § 10105, adding Internal Revenue Code § 45R(g)(2)).

<sup>50</sup> *Id.* § 1421 (as amended by Affordable Care Act § 10105, adding Internal Revenue Code § 45R(c)).

<sup>51</sup> *Id.* § 1421 (as amended by Affordable Care Act § 10105, adding Internal Revenue Code § 45R(b)).

<sup>52</sup> *Id.* § 1421 (as amended by Affordable Care Act § 10105, adding new Internal Revenue Code § 45R(e)(2)); *see also infra* Part II.C.

<sup>53</sup> 42 U.S.C. § 1395w-132 (2012).

<sup>54</sup> Treas. Reg. § 139A (2012).

<sup>55</sup> Affordable Care Act § 9012 (as amended by Reconciliation Act § 1407).

<sup>56</sup> *Id.* § 1102 (as amended by Affordable Care Act § 10102).

year).<sup>57</sup> Funded with only \$5 billion, the ERRP had disbursed \$4.73 billion by February 2012 and is now closed to new applicants.<sup>58</sup>

## 7. Miscellaneous Other Provisions (Non-Grandfathered Plans)

The Act also contains several provisions not currently applicable to grandfathered plans. For example, a non-grandfathered plan must provide 100% coverage of specified preventive care services and immunizations.<sup>59</sup> Such a plan must also follow extensive new internal and external claims processes<sup>60</sup> and may not require preauthorization or referral for obstetrical/gynecological and emergency room services or impose increased cost-sharing for emergency services.<sup>61</sup>

### *C. Provisions Effective in 2014*

All of the Act provisions effective before 2014 are minimal compared to the overhaul of the U.S. health insurance system scheduled to take effect in less than a year. Beginning in 2014, the Act establishes Health Insurance Exchanges intended to aid individuals in purchasing insurance policies that cover at least “essential health benefits.”<sup>62</sup> When that happens, health insurance in the United States will effectively cease to be discretionary. Individuals will be subject to tax penalties—phased in over several years—

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<sup>57</sup> *Id.* (as amended by Affordable Care Act § 10102); see also Press Release, White House, Fact Sheet: The Early Retiree Reinsurance Program (May 4, 2010), available at <http://www.whitehouse.gov/the-press-office/fact-sheet-early-retiree-reinsurance-program>.

<sup>58</sup> U.S. DEP'T. OF HEALTH & HUMAN SERVS., EARLY RETIREE REINSURANCE PROGRAM STATUS UPDATE (Feb. 2012).

<sup>59</sup> Affordable Care Act § 1001 (adding new Public Health Service Act § 2713). Regulations implementing the requirements specify that “a group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for [the specified items and services], and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services.” 29 C.F.R. 2590.715-2713(a)(1) (2012). Covered items or services include those with “a rating of A or B in the current recommendations of the United States Preventive Services Task Force” and “[i]mmunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention . . . .” *Id.* at (a)(1)(i)–(ii). For more details on covered items and services, see *Prevention, Wellness & Comparing Providers*, HEALTHCARE.GOV, <http://www.healthcare.gov/prevention/index.html> (last visited Apr. 29, 2013).

<sup>60</sup> Affordable Care Act § 1001 (as amended by Affordable Care Act § 10101(g), adding new Public Health Service Act § 2719A); see also 45 C.F.R. § 147.136 (2012).

<sup>61</sup> Affordable Care Act § 1001 (as amended by Affordable Care Act § 10101(h), adding new Public Health Service Act § 2719A); see also 45 C.F.R. § 147.138 (2012).

<sup>62</sup> See, e.g., *The Health Insurance Marketplace*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/features/choices/exchanges/index.html> (last updated Apr. 29, 2013). The term “Health Insurance Marketplace” is another term for the Health Insurance Exchanges established under the Act.

if they do not maintain “minimum essential coverage,” with exemptions for low-income individuals and certain other groups.<sup>63</sup> The term “minimum essential coverage” includes coverage under an employer-sponsored health plan that meets certain requirements.<sup>64</sup> Concurrently, larger employers will also be subject to penalties—a pay-or-play provision—if they fail to provide a specified level of health insurance.<sup>65</sup> So-called large employers—generally, those with an average of fifty or more full-time employees during the prior calendar year<sup>66</sup>—must pay an assessment of \$2,000 per full-time employee (excluding the first thirty such employees) if the employer does not offer “minimum essential coverage” and at least one such full-time employee obtains subsidized coverage through an Exchange.<sup>67</sup> This \$2,000-per-full-time-employee penalty applies without regard to how many employees receive federally subsidized coverage.<sup>68</sup> In other words, if just one full-time employee qualifies for and receives the subsidy, the employer must pay the \$2,000 for all full-time employees (after the first thirty).<sup>69</sup>

Moreover, in what is sometimes called a pay-and-play mandate, even if an employer does offer coverage to its employees, if a full-time employee opts out of employer coverage and enrolls in subsidized coverage through an Exchange instead, the employer must pay a penalty of \$3,000 for each such employee, subject to an overall cap of \$2,000 multiplied by the total number of full-time employees (after the first thirty).<sup>70</sup> No penalty applies with regard to employees who refuse employer-sponsored coverage and enroll in coverage through an Exchange, but who do not qualify for federally subsidized assistance in paying for the Exchange coverage.<sup>71</sup> In

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<sup>63</sup> Affordable Care Act § 1501(b) (as amended by Affordable Care Act § 10106(b)–(d) and Reconciliation Act § 1002, adding new Internal Revenue Code § 5000A).

<sup>64</sup> *Id.* (as amended by Affordable Care Act § 10106(b)–(d) and Reconciliation Act § 1002, adding new Internal Revenue Code § 5000A(f)).

<sup>65</sup> *Id.* § 1513(a) (as amended by Affordable Care Act § 10106(e)–(f) and Reconciliation Act § 1003, adding new Internal Revenue Code § 4980H).

<sup>66</sup> *Id.* (as amended by Affordable Care Act § 10106(e)–(f) and Reconciliation Act § 1003, adding new Internal Revenue Code § 4980H(c)(2)).

<sup>67</sup> *Id.* (as amended by Affordable Care Act § 10106(e)–(f) and Reconciliation Act § 1003, adding new Internal Revenue Code § 4980H(a)). The \$2,000 penalty amount is annualized. *Id.* The actual penalty computation is monthly. *Id.*

<sup>68</sup> *See id.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.* (as amended by Affordable Care Act § 10106(e)–(f) and Reconciliation Act § 1003, adding new Internal Revenue Code § 4980H(c)). The \$3,000 penalty amount is annualized. *Id.* The actual penalty computation is monthly. *Id.*

<sup>71</sup> Any “qualified individual” may enroll in a plan through an Exchange. *See id.* § 1312(a), (d). A “qualified individual” under the Act means “with respect to an Exchange, an individual who (i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and (ii) resides in the State that established the Exchange.” *Id.*

general, an employee eligible for employer-sponsored coverage can qualify for subsidized coverage through an Exchange only if the employee's household income does not exceed 400% of the federal poverty level for a family of the applicable size and either the employee's required contribution toward the cost of coverage exceeds 9.5% of the individual's household income or the employer plan does not cover at least 60% of the cost of minimum essential coverage.<sup>72</sup>

In addition to the various mandates, the Act requires employers that offer health insurance and have more than 200 full-time employees to automatically enroll new full-time employees in coverage, although employees may then opt out of coverage.<sup>73</sup> Waiting periods of more than ninety days for plan eligibility are also barred beginning in 2014, although the various agencies have indicated that they expect to issue regulations providing that the ninety-day limitation applies after an employee is otherwise eligible for coverage.<sup>74</sup> Non-grandfathered plans will be subject to limits on the level of participant deductibles and out-of-pocket maximums.<sup>75</sup>

At the same time that increased pressure is placed on employers to offer coverage at a certain level, significant reform to individual and small-group insurance markets will take effect.<sup>76</sup> Thus, individuals and small employers (generally, those with 100 or fewer employees) should be able to purchase regulated and standardized coverage packages through Exchanges.<sup>77</sup> States may permit larger employers to participate in the Exchanges beginning in 2017.<sup>78</sup> Among its many rules aimed at controlling health insurer behavior, the Act also requires all health insurers to offer guaranteed issue<sup>79</sup> and renewability<sup>80</sup> (meaning that an individual generally cannot be refused or dropped from coverage) and to base premiums on only a limited range of factors (such as family structure, geography, age, and tobacco use).<sup>81</sup>

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<sup>72</sup> *Id.* § 1401 (as amended by Affordable Care Act § 10105(a)–(d) and Reconciliation Act § 1001, adding new Internal Revenue Code § 36B(c)).

<sup>73</sup> *Id.* § 1511 (adding new Fair Labor Standards Act § 218A). The provision does not become effective until regulations are issued, and the Department of Labor has indicated that no such guidance will be available before 2014. See I.R.S. Notice 2012-17, 2012-9 I.R.B. 430.

<sup>74</sup> Affordable Care Act § 1201 (as amended by Affordable Care Act 10103, adding new Public Health Service Act § 2708); Reconciliation Act § 2301, 42 U.S.C. § 18011 (2012); see also I.R.S. Notice 2012-17, 2012-9 I.R.B. 430.

<sup>75</sup> Affordable Care Act § 1302(c).

<sup>76</sup> See *The Health Insurance Marketplace*, *supra* note 62.

<sup>77</sup> See *id.*

<sup>78</sup> Affordable Care Act § 1312(f)(2)(B).

<sup>79</sup> *Id.* § 1201 (adding new Public Health Service Act § 2702).

<sup>80</sup> *Id.* (adding new Public Health Service Act § 2703).

<sup>81</sup> *Id.* (adding new Public Health Service Act § 2701).

### *D. Delayed Provision (Generally Effective in 2018)*

If the law remains as currently written, a 40% “Cadillac plan” excise tax will be imposed beginning in 2018 for employer-sponsored health insurance coverage worth more than \$10,200 per individual (or \$27,500 per family), with adjustments upward in those amounts for early retirees and individuals in certain other categories, including high-risk industries, where increased health costs may be likely.<sup>82</sup> By some estimates, as many as 60% of large-employer plans might find themselves subject to the penalty based on their current provisions.<sup>83</sup>

### III. SUPREME COURT REVIEW OF THE ACT

A number of lawsuits targeted the Act on various grounds almost immediately after President Obama signed the Affordable Care Act on March 23, 2010.<sup>84</sup> By mid-November 2011, when the Supreme Court granted certiorari in three of the cases (consolidated for purposes of Supreme Court review),<sup>85</sup> a total of twenty-six separate federal lawsuits were winding their way through the court system.<sup>86</sup> The primary target of the challenges was the individual health insurance mandate,<sup>87</sup> although a

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<sup>82</sup> *Id.* § 9001(a) (as amended by Affordable Care Act § 10901); Reconciliation Act § 1401 (adding new Internal Revenue Code § 4980I).

<sup>83</sup> See, e.g., *Cadillac Health Plan Tax to Penalize Majority of Employers by 2018*, BUSINESSWIRE (May 19, 2010, 11:21 AM), <http://www.businesswire.com/news/home/20100519006444/en/Cadillac-Health-Plan-Tax-Penalize-Majority-Employers>.

<sup>84</sup> For example, Complaint, *Florida v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256 (N.D. Fla. 2011) (No. 3:10-cv-91-RV/EMT), was filed on March 23, 2010, the same day the Act was signed into law. This first challenge came from the attorney general of Florida and twelve other state attorneys general. See KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: A GUIDE TO THE SUPREME COURT'S AFFORDABLE CARE ACT DECISION 1 (2012), available at <http://www.kff.org/healthreform/upload/8332.pdf>. Eventually, the National Federation of Independent Business and thirteen additional state attorneys general joined. See *id.* This case became the basis for Supreme Court review in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012).

<sup>85</sup> See U.S. Supreme Court, Certiorari Grant Order (Nov. 14, 2011), available at <http://www.supremecourt.gov/docket/PDFs/111411zr.pdf>.

<sup>86</sup> Bara Vaida & Karl Eisenhower, *Scoreboard: Tracking Health Law Court Challenges*, KAISER HEALTH NEWS, <http://www.kaiserhealthnews.org/stories/2011/march/02/health-reform-law-court-case-status.aspx#florida> (last updated Nov. 14, 2011) (providing a useful compilation of the health reform litigation through mid-November 2011).

<sup>87</sup> See, e.g., Petition for Writ of Certiorari at i, *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) (No. 11-393) (summarizing the question presented as “whether the ACA must be invalidated in its entirety because it is nonseverable from the individual mandate that exceeds Congress’ limited and enumerated powers under the Constitution”); Petition for Writ of Certiorari at i, *U.S. Dep’t of Health & Human Servs. v. Florida*, 132 S. Ct. 604 (2011) (No. 11-398) (summarizing the question presented as “[w]hether Congress had the power under Article I of the Constitution to enact the

challenge to the Act's Medicaid expansion also reached the Supreme Court.<sup>88</sup> In the end, the Supreme Court considered not only whether the individual mandate by itself exceeded congressional authority, but also whether the mandate could be severed from the remainder of the statute as well as whether the Medicaid provisions were constitutional.<sup>89</sup>

Although the challenges considered by the Supreme Court did not directly attack the various employer requirements discussed above,<sup>90</sup> the

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minimum coverage provision[.]" better known as the individual mandate, and urging the Supreme Court also to consider "[w]hether the suit brought by respondents to challenge the minimum coverage provision of the Patient Protection and Affordable Care Act is barred by the Anti-Injunction Act, 26 U.S.C. §7421(a)"; Petition for Writ of Certiorari at i, *Thomas More Law Ctr. v. Obama*, 651 F.3d 529 (6th Cir. 2011) (No. 10-2388) (stating that "[t]his case challenges Congress's authority to require private citizens to purchase and maintain 'minimum essential' healthcare insurance coverage under penalty of federal law[.]" and summarizing the questions presented as whether Congress has "authority under the Commerce Clause to require private citizens to purchase and maintain 'minimum essential' healthcare insurance coverage under penalty of federal law" and whether "the individual mandate provision of the Act [is] unconstitutional as applied to Petitioners who are without healthcare insurance"); Petition for Writ of Certiorari at i, *Florida v. U.S. Dep't of Health & Human Servs.*, 132 S. Ct. 604 (2011) (No. 11-400) (summarizing the questions presented as including the issue of whether "the Affordable Care Act's mandate that virtually every individual obtain health insurance exceed[s] Congress's enumerated powers and, if so, to what extent (if any) can the mandate be severed from the remainder of the Act"); Petition for Writ of Certiorari at i, *Virginia v. Sebelius*, 656 F.3d 253 (2011) (No. 11-420) (summarizing the questions presented as including the issue of "[w]hether the power claimed by Congress in the Patient Protection and Affordable Care Act (PPACA) to mandate that a citizen purchase a good or service from another citizen is unconstitutional because the claimed power exceeds the outer limits of the Commerce Clause even as executed by the Necessary and Proper Clause"); Petition for Writ of Certiorari at i, *Liberty Univ. v. Geithner*, 671 F.3d 391 (2011) (No. 11-438) (summarizing the questions presented as including the issue of "[w]hether Congress exceeded its enumerated powers by enacting a novel and unprecedented law that forces individuals who otherwise are not market participants to enter the stream of commerce and purchase a comprehensive but vaguely defined and burdensome health insurance product, and if so, to what extent can this essential part of the statutory scheme be severed").

<sup>88</sup> See, e.g., Petition for Writ of Certiorari at i, *Florida*, 132 S. Ct. 604 (No.11-400) (summarizing the questions presented as including the issue of whether "Congress exceed[s] its enumerated powers and violate[s] basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program").

<sup>89</sup> In its grant of certiorari, the Supreme Court accepted the individual mandate question from Petition for Writ of Certiorari at i, *Nat'l Fed. of Indep. Bus.*, 132 S. Ct. 2566 (No. 11-393), and the severability question from Petition for Writ of Certiorari at i, *Florida*, 132 S. Ct. 604 (No. 11-400), consolidating the cases for hearing. The Court also accepted the individual mandate question from Petition for Writ of Certiorari at i, *U.S. Dep't of Health & Human Servs.*, 132 S. Ct. 604 (No. 11-398), in addition to directing the parties to brief the Anti-Injunction Act question raised by petitioners. Finally, the Court accepted the Medicaid question from Petition for Writ of Certiorari at i, *Florida*, 132 S. Ct. 604 (No. 11-400). See U.S. Supreme Court, *Certiorari Grant Order* (Nov. 14, 2011), available at <http://www.supremecourt.gov/docket/PDFs/111411zr.pdf>.

<sup>90</sup> The Supreme Court also heard arguments relating to Medicaid provisions contained in the Act, but those are far removed from the employer concerns discussed herein. For a convenient summary of the issues, see KAISER FAMILY FOUND., *A Guide to the Supreme Court's Review of the 2010 Health Care Reform Law* (2012), available at <http://www.kff.org/healthreform/upload/8270-2.pdf>.

survival or failure of the individual mandate raised significant concerns for the remainder of the Act.<sup>91</sup> Without the individual mandate, the economics underpinning many of the broader provisions of the Act fail.<sup>92</sup> The Act imposes significant restrictions on how private insurers operate their businesses.<sup>93</sup> In general, these restrictions undercut insurers' ability to manage risk by limiting insurers' ability to issue insurance only to those who seem relatively unlikely to use much—in other words, in the case of health insurance, people who are comparatively healthy.<sup>94</sup> The Act partially compensates insurers for that loss of risk-management control by forcing significantly more individuals to purchase insurance. The more individuals covered, the greater an insurer's ability to spread risk. Without the individual mandate, however, insurers lose that ability,<sup>95</sup> leaving them vulnerable to significant adverse-selection problems.<sup>96</sup>

<sup>91</sup> See generally CONG. BUDGET OFFICE, EFFECTS OF ELIMINATING THE INDIVIDUAL MANDATE TO OBTAIN HEALTH INSURANCE (2010), available at [http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/eliminate\\_individual\\_mandate\\_06\\_16.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/eliminate_individual_mandate_06_16.pdf).

<sup>92</sup> Arguments both in favor of and against the individual mandate proliferated both before and since the Act's passage. See, e.g., LINDA J. BLUMBERG ET AL., THE INDIVIDUAL MANDATE IN PERSPECTIVE: TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES 2 (2012), available at <http://www.urban.org/UploadedPDF/412533-the-individual-mandate.pdf> (suggesting that, while relatively small numbers of individuals may be directly affected by the mandate, the presence of the requirements "leads to lower premiums and more stable insurance markets than would be the case without it"); Stewart Jay, *On Slippery Constitutional Slopes and the Affordable Care Act*, 44 CONN. L. REV. 1133, 1133 (2012) (concluding shortly before the Supreme Court decision that the individual mandate could be "justified under both the Commerce Clause (as augmented by the Necessary and Proper Clause) and the General Welfare Clause"); Mark Merlis, *Health Policy Brief: Individual Mandate*, HEALTH AFF. (Jan. 13, 2010), <http://www.rwjf.org/files/research/54508.pdf> (providing an overview of the individual mandate issues under consideration in the months immediately before passage of the Act in 2010); Glen Whitman, *Hazards of the Individual Health Care Mandate*, CATO POL'Y REP. Sept./Oct. 2007, at 1, 10, available at [http://www.cato.org/pubs/policy\\_report/v29n5/cpr29n5-1.html](http://www.cato.org/pubs/policy_report/v29n5/cpr29n5-1.html) (critiquing the individual mandate concept several years before it became enshrined in the Act).

<sup>93</sup> See, e.g., Charles P. Litchfield, Note, *Taxing Youth: Health Care Reform Writes a Costly Prescription That Leaves the Young and Healthy Paying the Bill*, 85 S. CAL. L. REV. 353, 356–61 (2012).

<sup>94</sup> See, e.g., *id.* at 358–61. The Act also limits—and eventually eliminates—insurers' ability to reduce their risk of high claims by excluding pre-existing conditions. *Id.* at 356. To the extent that the individual mandate expands the number of people covered, it increases insurers' potential premium revenues, helping offset losses that may result from the Act's prohibition on pre-existing condition limitations.

<sup>95</sup> See, e.g., Peter J. Kalis & Judy Hlafcsak, *Healthcare Reform: Let's Act Locally*, 50 DUQ. L. REV. 253, 256 (2012) (observing that, "[i]f the individual mandate is gone, but insurers are required to cover pre-existing conditions, there is little incentive for young, healthy individuals to purchase coverage. After all, they can just wait until they get sick and then purchase insurance, since the insurer cannot refuse to cover preexisting conditions. If that phenomenon occurs, the insurance pool will be too heavily weighted with high utilizers of medical care, causing overall premiums to increase and coverage to become unaffordable.").

<sup>96</sup> The issues raised by the possibility that the Supreme Court might strike down the individual

Concern over the ramifications of the Supreme Court's striking down the individual mandate ended when the Court in late June 2012 upheld the Act largely as written, limiting its impact only in the context of Medicaid.<sup>97</sup> Chief Justice Roberts, writing for the majority in a sharply divided 5-4 decision,<sup>98</sup> refused to uphold the individual mandate on Commerce Clause grounds.<sup>99</sup> The majority agreed, however, that the mandate could be evaluated alternatively "not as ordering individuals to buy insurance, but rather as imposing a tax on those who do not buy that product."<sup>100</sup> Proceeding along this path,<sup>101</sup> the majority concluded: "Because the Constitution permits such a tax, it is not our role to forbid it . . . ."<sup>102</sup> While hardly a ringing endorsement,<sup>103</sup> the decision sufficed to allow the Act to go forward with the mandate intact.<sup>104</sup>

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mandate extended far beyond the impact on insurers described in the text. See, e.g., Mark A. Hall, *Constitutional Mortality: Precedential Effects of Striking the Individual Mandate*, 75 LAW & CONTEMP. PROBS. 107 (2012); Leslie Meltzer Henry & Maxwell L. Stearns, *Commerce Games and the Individual Mandate*, 100 GEO. L.J. 1117, 1155–56 (2012).

<sup>97</sup> Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

<sup>98</sup> See *id.* Just how sharply divided has become increasingly clear since the Court announced its decision. A rare degree of disclosure about the Court's behind-the-scenes turmoil over the decision has leaked into public view. See, e.g., JEFFREY TOOBIN, *THE OATH: THE OBAMA WHITE HOUSE AND THE SUPREME COURT* 283–89 (2012).

<sup>99</sup> Nat'l Fed'n of Indep. Bus., 132 S. Ct. at 2593 ("The commerce power . . . does not authorize the mandate.").

<sup>100</sup> *Id.*

<sup>101</sup> See *id.* at 2600 ("The Affordable Care Act's requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax.").

<sup>102</sup> *Id.*

<sup>103</sup> See *id.* While holding that the Supreme Court's job is not to "forbid" a tax that the Constitution permits, Roberts continued that it is also not the Court's job "to pass upon its wisdom or fairness." *Id.*

<sup>104</sup> See *id.* at 2601. A key part of the Act's Medicaid expansion structure was not so fortunate. Characterizing the structure as "a gun to the head" of the states, the majority ruled that the federal government could not withhold all federal Medicaid funding from a state if the state refused to expand Medicaid in accordance with the Act. *Id.* at 2603–04. Medicaid is a jointly funded program that provides health care to certain categories of the impoverished. *Medicaid: By Population*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/By-Population.html> (last visited Apr. 29, 2013). Within the broad framework established under federal law, each state develops its own Medicaid program. See, e.g., *New York State Medicaid State Plan*, N.Y. DEP'T OF HEALTH, [http://www.health.ny.gov/regulations/state\\_plans/](http://www.health.ny.gov/regulations/state_plans/) (last updated July 2012). The Act adds categories and relaxes the limitations on the level of income and assets a person may have in order to qualify for Medicaid. See JOHN HOLAHAN & IRENE HEADEN, URBAN INST. & KAISER COMM'N ON MEDICAID & THE UNINSURED, *MEDICAID COVERAGE AND SPENDING IN HEALTH REFORM: NATIONAL AND STATE-BY-STATE RESULTS FOR ADULTS AT OR BELOW 133% FPL* 9 (2010), available at <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf> (providing a detailed analysis of the potential impact of the Act on state Medicaid coverage). In order to accomplish its goal, the Act made not only new federal Medicaid funding conditional on a state's acceptance of the Medicaid expansion, but also gave the Secretary of HHS the power to discontinue existing Medicaid funding. See 42 U.S.C. § 1396c (2012). The Supreme Court majority found this unacceptable: "Congress is not free . . . to penalize States that choose not to participate in that new program by taking away their existing Medicaid



## IV. SEARCHING THE CRYSTAL BALL: THE UNCERTAIN FUTURE

Uncertainty remained in the fall of 2012. Although the Supreme Court settled the constitutionality of the individual mandate, litigation over other aspects of the Act continued.<sup>105</sup> As with the issues that have now passed through the highest court, relatively little of the pending litigation directly affected employers.<sup>106</sup> As November 2012 neared, the looming presidential and congressional elections seemed more likely to affect employer plans than any of the lawsuits. Although Republican presidential candidate Mitt Romney softened his tone on elements of the Act as the election approached,<sup>107</sup> his running mate, Paul Ryan, did not.<sup>108</sup> The Republican National Party platform for 2012 pronounced: "Congressional Republicans are committed to [the Act's] repeal; and a Republican President, on the first day in office, will use his legitimate waiver authority under that law to halt

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funding." *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2607. A different majority of justices felt, however, that the problem could be remedied by limiting the Secretary's implementation power. *Id.* at 2642 (Ginsburg, J., concurring in part). For a useful overview of the Medicaid part of the ruling, see KAISER FAMILY FOUND., A GUIDE TO THE SUPREME COURT'S DECISION ON THE ACA'S MEDICAID EXPANSION 1 (2012), available at <http://www.kff.org/healthreform/upload/8347.pdf>.

<sup>105</sup> See Timothy Jost, *The March of Affordable Care Act Litigation Goes On*, HEALTH AFF. BLOG (Sept. 9, 2012, 10:32 AM), <http://healthaffairs.org/blog/2012/09/09/the-march-of-affordable-care-act-litigation-goes-on/> (providing an overview of ongoing lawsuits over health reform).

<sup>106</sup> One exception involved cases on the Act's contraceptive coverage requirements, which directly affect certain employers. The Act requires that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall . . . provide coverage for and shall not impose any cost sharing requirements" for certain "preventive care and screenings" for women. 42 U.S.C. § 300gg-13(a), (13)(a)(4) (2012). The list of preventive care eventually issued by the Health Resources and Services Administration included "contraceptive methods." See *Women's Preventive Services: Required Health Plan Coverage Guidelines*, HEALTH RES. & SERVS. ADMIN., <http://www.hrsa.gov/womensguidelines/> (last visited Apr. 28, 2013). After considerable uproar, a regulatory exception was added to exempt religious employers from the contraceptive requirement. See 77 Fed. Reg. 8725 (Feb. 15, 2012) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pt. 147). Notwithstanding this, a number of cases were filed challenging the contraceptive coverage provisions. See, e.g., *Wheaton Coll. v. Sebelius*, No. 12-1169, 2012 WL 3637162 (D.D.C. Aug. 24, 2012) (dismissed).

<sup>107</sup> See, e.g., Kate Pickert, *Mitt Romney's Confusing Health Care Comments*, TIME: SWAMPLAND (Sept. 10, 2012), <http://swampland.time.com/2012/09/10/mitt-romneys-confusing-health-care-comments/> (quoting Mr. Romney from an interview on *Meet the Press* as saying "I'm not getting rid of all of health care reform. Of course, there are a number of things that I like in health care reform that I'm going to put in place."). Such comments notwithstanding, the healthcare issues page on Mr. Romney's candidate website continued to carry the headline: "Repeal and Replace Obamacare." *Issues: Health Care*, MITT ROMNEY FOR PRESIDENT, <http://www.mittromney.com/issues/health-care> (webpage no longer available).

<sup>108</sup> See, e.g., Felicia Sonmez, *Ryan Booed at AARP*, WASH. POST (Sept. 21, 2012, 1:20 PM), <http://www.washingtonpost.com/blogs/election-2012/wp/2012/09/21/paul-ryan-booed-at-aarp-after-pledging-obamacare-repeal/?print=1> (describing how the Republican vice presidential candidate was repeatedly booed during an AARP meeting for his calls to repeal the Act).

its progress and then will sign its repeal.”<sup>109</sup> Meanwhile, the Democratic National Party platform claimed that the “Act lays a new foundation for our country that will bring additional security and stability to the American people for generations to come.”<sup>110</sup> With a handful of weeks remaining before the election, who would win remained shrouded in doubt.<sup>111</sup>

Employers in the fall of 2012 thus occupied an unenviable position, with the two major-party presidential candidates on opposite sides of the Act. While the Act’s 2014 provisions could take hold, the possibility also remained that a significant Republican win could cause course reversal. Even if the Act survived, additional uncertainty existed for employers because of the freedom left to the states in making implementation choices. Traditionally, under the McCarran-Ferguson Act, states—not the federal government—regulate the business of insurance within their boundaries.<sup>112</sup> The Act, however, includes an array of insurance-market reforms that will necessarily affect insurance companies.<sup>113</sup> In an effort to preserve at least some of the traditional division of responsibility, the Act cedes significant decision-making authority to the states,<sup>114</sup> but only if they take the responsibility.<sup>115</sup> If a state refuses or neglects to adopt—in the words of the legislation, to “substantially enforce”—the various reforms required by the Act, the Secretary of HHS is directed to “enforce a provision (or provisions) . . . insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans or individual health insurance coverage in such State.”<sup>116</sup>

State responses to the Act by the fall of 2012 covered a wide range. A small number had moved relatively far along the implementation path, at

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<sup>109</sup> *Renewing American Values: Republican Party Platform*, GOP.COM, [http://www.gop.com/2012-republican-platform\\_Renewing/#Item6](http://www.gop.com/2012-republican-platform_Renewing/#Item6) (last visited Apr. 29, 2013).

<sup>110</sup> Democratic Nat’l Comm., *Issues: Health Care*, DEMOCRATS.ORG, [http://www.democrats.org/issues/health\\_care](http://www.democrats.org/issues/health_care) (last visited Apr. 29, 2013).

<sup>111</sup> See, e.g., Peter Baker & Eric Lipton, *In a Tight Race, Obama Draws on the Levers of His Power*, N.Y. TIMES, Sept. 19, 2012, at A1, available at <http://www.nytimes.com/2012/09/20/us/politics/obama-exploits-familiar-junction-of-policy-and-politics.html?pagewanted=all>; Jeff Zeleny & Jim Rutenberg, *Before Debates, Romney Faces a Daunting Path*, N.Y. TIMES, Sept. 20, 2012, at A1, available at <http://www.nytimes.com/2012/09/21/us/politics/romney-faces-an-uphill-fight-to-win-atpolls.html?pagewanted=all>.

<sup>112</sup> McCarran-Ferguson Act, Pub. L. No. 79-15, 59 Stat. 33 (codified as amended at 15 U.S.C. §§ 1011–1015 (2012)).

<sup>113</sup> 43 U.S.C. § 300gg-22(a) (2012).

<sup>114</sup> *Id.* (providing that “each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual or group market meet the requirements of this part with respect to such issuers”).

<sup>115</sup> *Id.* § 300gg-22(a)(2).

<sup>116</sup> *Id.*

least with regard to the insurance-market reforms.<sup>117</sup> Half of the states, of course, had joined the litigation against the Act.<sup>118</sup> At least in Kentucky, the governor seemingly capitulated in the wake of the Supreme Court's decision.<sup>119</sup> Some governors, however, maintained vocal opposition to accepting any new responsibilities,<sup>120</sup> and a number of state legislatures stayed firmly opposed to the Act.<sup>121</sup> Central among the targets of opposition has been establishment of the Exchanges.<sup>122</sup> The Act allows each state to create its own Exchange, establish an Exchange in partnership with the federal government, or ignore the whole idea and let the federal government operate an Exchange for the state.<sup>123</sup> By late November 2012, seventeen states plus the District of Columbia had decided to establish their own Exchanges.<sup>124</sup> Another seventeen states had affirmatively thrown the ball back to the federal government, six planned to operate partnership Exchanges, but ten remained undecided.<sup>125</sup> Employers thus ended 2012

<sup>117</sup> See, e.g., KEVIN LUCIA ET AL., GEORGETOWN UNIV. HEALTH POLICY INST., CROSS-CUTTING ISSUES: MONITORING STATE IMPLEMENTATION OF THE AFFORDABLE CARE ACT IN 10 STATES: EARLY MARKET REFORMS (2012), available at <http://www.urban.org/UploadedPDF/412650-Monitoring-State-Implementation-of-the-Affordable-Care-Act-in-10-States.pdf> (reporting on the progress of ten states being tracked in a joint Urban Institute/Robert Wood Johnson Foundation project to monitor state implementation of the Act).

<sup>118</sup> See Vaida & Eisenhower, *supra* note 86.

<sup>119</sup> See Press Release, Gov. Steve Beshear's Commc'ns Office, Gov. Beshear Issues Executive Order Creating Kentucky Health Benefit Exchange (July 17, 2012), available at <http://migration.kentucky.gov/Newsroom/governor/20120717healthexchangeadvisoryboard.htm>.

<sup>120</sup> See, e.g., Letter from Rick Perry, Governor, Tex., to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (July 9, 2012), available at <http://governor.state.tx.us/files/press-office/O-SebeliusKathleen201207090024.pdf> (characterizing the Act as a "brazen intrusion[] into the sovereignty" of Texas and an "unsound encroachment"); *After Supreme Court Ruling, States Say 'Yes' and 'No' to State Health Insurance Exchanges*, PATIENT PROTECTION & AFFORDABLE CARE ACT: STATE ACTION NEWSLETTER (Nat'l Conference of State Legislatures), July 27, 2012, at 1-2, available at <http://www.ncsl.org/documents/health/ACANews38.pdf>.

<sup>121</sup> See, e.g., Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms*, NAT'L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/issues-research/health/state-laws-and-actions-challenging-ppaca.aspx> (last updated Jan. 2013) (compiling state action with regard to the Act and estimating that, "[a]s of January 1, 2013, 20 state legislatures had enacted laws and measures related to challenging or opting out of broad health reform including the Patient Protection and Affordable Care Act (PPACA)").

<sup>122</sup> Robert Pear, *Brawling Over Health Care Moves to Rules on Exchanges*, N.Y. TIMES, July 8, 2012, at A14, available at <http://www.nytimes.com/2012/07/08/us/critics-of-health-care-law-prepare-to-battle-over-insurance-exchange-subsidies.html>.

<sup>123</sup> See KAISER FAMILY FOUND., ESTABLISHING HEALTH INSURANCE EXCHANGES: AN OVERVIEW OF STATE EFFORTS I (2012), available at <http://www.kff.org/healthreform/upload/8213-2.pdf>.

<sup>124</sup> *Id.*

<sup>125</sup> *Id.* For a helpful and regularly updated status table on the states and their progress toward making decisions on establishing Exchanges, see Kaiser Family Found., *State Action Toward Creating Health Insurance Exchanges, as of March 21, 2013*, STATE HEALTH FACTS, <http://statehealthfacts.kff.org/comparemappable.jsp?ind=962&cat=17> (last updated Mar. 21, 2013).

unsure in many cases what a particular state would do. Moving forward, such uncertainty is a particular problem for larger employers with employees in more than one state. But even for employers centered in only one place, until the Exchanges are in place, questions remain, muddying the planning process.

On the other hand, a number of Act provisions are already in effect and not in doubt. In each case, employers have already invested time and money in compliance. Admittedly, much of the cost may have passed through the employers and down to covered employees,<sup>126</sup> but at least initial increased costs due to Act compliance may have stabilized.<sup>127</sup> Moreover, some of the Act's initial rules may be comparatively inexpensive for many employers. For example, younger individuals are usually comparatively healthy.<sup>128</sup> Allowing their parents to maintain coverage under an employer's plan in most cases is unlikely to drive costs up dramatically simply due to the health status of most people under age twenty-six.<sup>129</sup> Meanwhile, relieving parents and adult children of the stress of not having coverage is a clear benefit. This creates an opportunity for employers to improve benefit offerings—with all the positive ramifications for employee recruitment, morale, and retention—at comparatively low cost. Perhaps not surprisingly, shortly after the Act became law but before its requirements took effect, many large health insurers announced that they would immediately extend coverage to children under age twenty-six.<sup>130</sup> Similarly, in the weeks leading up to the Supreme Court decision, UnitedHealthcare announced that it would “continue provisions related to coverage of preventive health care services, coverage of dependents up to

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<sup>126</sup> The average annual family premium for health insurance coverage jumped from \$13,770 in 2010, the year the Act passed, to \$15,073 in 2011, the first year in which significant Act requirements began to take effect—an almost 9.5% increase. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, *EMPLOYER HEALTH BENEFITS: 2012 ANNUAL SURVEY* 30 (2012) [hereinafter KAISER EMPLOYER BENEFITS 2012 SURVEY], available at <http://ehbs.kff.org/?page=charts&id=1&sn=6&ch=2659>.

<sup>127</sup> *Id.* From 2011 to 2012, the average annual family premium for health insurance coverage increased only 4%—up to \$15,745 from \$15,073. *Id.*

<sup>128</sup> See, e.g., Mark W. Stanton, *The High Concentration of U.S. Health Care Expenditures*, RES. IN ACTION, June 2006, at 1, 4, available at <http://www.ahrq.gov/legacy/research/trial19/expendria.htm> (reporting that even the top 5% of healthcare spenders in the age 19–34 age group incur only 9% of all U.S. healthcare costs as compared to the top 5% of spenders in other age groups).

<sup>129</sup> See *id.*

<sup>130</sup> See Press Release, White House, Fact Sheet: Young Adults and the Affordable Care Act (Apr. 27, 2010), available at <http://www.whitehouse.gov/the-press-office/fact-sheet-young-adults-and-affordable-care-act>. It was initially unclear how many employers will take advantage of this option. See, e.g., Michelle Andrews, *Why Won't My Insurance Cover My Son Until 2011?*, N.Y. TIMES PRESCRIPTIONS BLOG (May 24, 2010, 9:00 AM), <http://prescriptions.blogs.nytimes.com/2010/05/24/why-cant-i-cover-my-son-until-2011/?hpw>.

age 26, lifetime policy limits, rescissions and appeals” without regard to whether or not the Supreme Court struck down the Act.<sup>131</sup>

Coverage of dependents to age twenty-six has been popular. By 2012, 90% of larger employers reported having enrolled at least one adult child in a plan, and a total of approximately 2.9 million adult children had coverage, in both cases due to the Act’s requirements.<sup>132</sup> So, too, the Act’s requirements of expanded preventive services coverage have affected large numbers of plans. In 2012, 41% of covered workers experienced changed preventive services coverage as a direct result of the Act even though not all participated in plans for which the Act mandated changes.<sup>133</sup> Assuming the costs of these and similar Act changes are not overwhelming, employers were unlikely to move backward even had 2012 turned out differently. As the CEO of one Blue Cross/Blue Shield organization said shortly before the Supreme Court decision, “[T]he genie is out of the bottle. We’re far enough into the revolution now that I don’t see how the political leadership can completely sweep it away.”<sup>134</sup>

It is worth considering that most of the pre-2014 Act rules constitute the kind of incremental law changes that Congress has used to tweak employer plan regulation ever since ERISA. Rather than completely rewriting benefits-related rules, from the 1970s through present day, Congress has tended to chip away at perceived problems, fixing issues one by one with targeted legislation. Thus, for example, the Consolidated Omnibus Budget Reconciliation Act of 1985<sup>135</sup> (better known as “COBRA”) gives individuals the ability to maintain coverage for at least an eighteen-month transition period after terminating employment,<sup>136</sup> long enough—at least in theory—for most workers to obtain new employment with new coverage. The Family and Medical Leave Act of 1993<sup>137</sup> (“FMLA”) provides workers the ability to take much-needed leaves of absence, without losing

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<sup>131</sup> Press Release, UnitedHealth Grp., UnitedHealthcare Voluntarily Extends Important Health Reform Protections Regardless of Upcoming Rulings by Supreme Court (June 11, 2012), available at [http://www.uhc.com/news\\_room/2012\\_news\\_release\\_archive/health\\_reform\\_protections\\_to\\_be\\_extended.htm](http://www.uhc.com/news_room/2012_news_release_archive/health_reform_protections_to_be_extended.htm).

<sup>132</sup> See KAISER EMPLOYER BENEFITS 2012 SURVEY, *supra* note 126, at 225, 230.

<sup>133</sup> *Id.* at 232.

<sup>134</sup> Jay Hancock, *Some Health System Changes Will Stay, No Matter How SCOTUS Rules*, KAISER HEALTH NEWS (June 19, 2012), <http://www.kaiserhealthnews.org/Stories/2012/June/19/health-system-changes-supreme-court.aspx?p=1>.

<sup>135</sup> Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (codified as amended in scattered sections of U.S.C.).

<sup>136</sup> See, e.g., EMP. BENEFITS SEC. ADMIN., U.S. DEP’T OF LABOR, AN EMPLOYEE’S GUIDE TO HEALTH BENEFITS UNDER COBRA: THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT 13 (2010), available at <http://www.dol.gov/ebsa/pdf/cobraemployee.pdf>.

<sup>137</sup> Family and Medical Leave Act of 1993, Pub. L. No. 103-3, 107 Stat. 6 (codified as amended in scattered sections of 5 U.S.C. and 29 U.S.C.).

employment-based health insurance, to manage periods of healthcare needs, whether an employee's own or that of a family member.<sup>138</sup> The Health Insurance Portability and Accountability Act of 1996<sup>139</sup> ("HIPAA"), in addition to imposing health information privacy requirements, greatly reduces "job lock" due to health insurance and gives workers the ability to apply past coverage periods toward pre-existing coverage limitations in a new employer's plan.<sup>140</sup> Michelle's Law, enacted in 2008, prevents group health plans from terminating coverage for certain students who lose their full-time status due to illness.<sup>141</sup> In each case, Congress focused on a particular issue and created legislation to resolve that particular problem. While employers do not gladly embrace new obligations, after the initial grumbling quiets, the new change becomes just one more benefits rule for employers to follow. The Act provisions already in place fit easily into the model of such past rule changes.

## V. CONCLUSION

What should employers do going forward? That is difficult to say while still in the transition to 2014. Might employers have wearied of providing increasingly expensive health benefits, yet feel trapped by social expectations and historic obligations? To some degree, the ongoing growth of high-deductible health plans and other comparable defined-contribution-model employee health insurance plans hints at just this.<sup>142</sup> From such perspective, employers might have good reason, if not to support the Act, at least not to oppose it. If the Exchanges achieve their promise, many employers will be able to choose between accepting pay-or-play (or pay-and-play) penalties or providing health insurance themselves.<sup>143</sup> That choice invites a straightforward cost-benefit analysis. If an employer believes employees have viable options outside the employment relationship, that employer may well adopt the lowest cost alternative.

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<sup>138</sup> See, e.g., WAGE & HOUR DIV., U.S. DEP'T OF LABOR, NEED TIME? THE EMPLOYEE'S GUIDE TO THE FAMILY AND MEDICAL LEAVE ACT 6 (2012), available at [http://www.dol.gov/whd/fmla/employee\\_guide.pdf](http://www.dol.gov/whd/fmla/employee_guide.pdf).

<sup>139</sup> Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 18, 26, 29, & 42 U.S.C.).

<sup>140</sup> See, e.g., *Fact Sheet: The Health Insurance Portability and Accountability Act (HIPAA)*, U.S. DEP'T OF LABOR (Dec. 2004), <http://www.dol.gov/ebsa/newsroom/fshipaa.html>.

<sup>141</sup> Michelle's Law, Pub. L. No. 110-381, 122 Stat. 4081 (codified at 42 U.S.C.).

<sup>142</sup> By 2012, 39% of workers covered by an employment-based health plan were offered a high-deductible health plan option. KAISER EMPLOYER BENEFITS 2012 SURVEY, *supra* note 126, at 68.

<sup>143</sup> See *supra* Part II.C.

How does an employer move from one model to another without risking a significant hit to employee morale and public opinion? The Act could offer an escape hatch here. Because of health reform's penalty system, employers could terminate their existing plans, blame the decision on the Act, and direct ire away from themselves. Instead of viewing the Act as coercive and chafing against its burdens, employers could use its provisions for their own benefit. Focusing on what the Act enables for them rather than what the Act requires of them could fundamentally shift the calculus. Any such shift, however, likely depends on effective implementation of the Exchanges across the various states and the resulting public perception of health reform. Unfortunately, both will take time to develop, leaving employers perhaps more secure than in 2012 but still struggling with uncertainty.